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MARYLAND LEGISLATION ON HOSFITAL RATE REGULATION:

A HISTORICAL PERSPECTIVE OF POLICY DEVELOPMENT

Submitted for the requirements of the GVPT Departmental Honors Program by:

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Beginning on July 1, 1974 the Maryland State Health Services Cost Review Commission (HSCRC) will have the legal responsibility to determine the rates that hospitals may charge for their services. According to law these rates must be reasonably related to the hospital's costs, which in turn are to be reasonably related to the total services offered by the hospital; additionally the rates are to be set equitably among all purchasers or classes of purchasers of services without undue discrimination. The power of the Commission was the subject of legislation introduced in the House of Delegates as early as 1967, but not until 1971 was the bill that provided for hospital rate regulation passed by the Maryland Legislature.

The story behind the legislative history of the HSCRC is an interesting one. As much occurred in private meetings in offices and cocktail lounges as on the floor of the Legislature. An overview of the history can be most easily demonstrated through the use of a short parable that is as instructive as it is entertaining: Once upon a time there was a sick man in the hospital. Not only was he sick but his was a contagious disease and the doctors in charge of his case were quite anxious to cure him as they felt the disease this patient had could spread among the general

population. However, the two doctors soon found they had a very difficult patient, he refused to voluntarily accept any of the treatment they wanted to give him. This situation continued for a few days and eventually the doctors became quite concerned as they felt they had a strong responsibility to the public and decided to have a conference to determine a course of action. At this conference they decided they could wait no longer and the patient had to be treated immediately and given medication, despite his wishes to the contrary. However, though the doctors believed the patient was asleep during their consultations, he had overheard them and developed a plan of his own. He called the doctors into his room and said, "I realize I have been a great strain on you and now it is time for me to be treated." The patient then told the doctors he would take the pill they wanted to treat him with but he carried the idea a bit farther than the doctors had expected. Not only did he want the prescribed medication but he wanted added ingredients to make himself even stronger. He also wanted other enticements, like extra lubricants to help the pill slide down his throat very easily. The doctors were quite satisfied with this idea, they felt their primary responsibility was to cure the patient, and the plan was accepted and readily carried out. And, in fact, the story would have ended here except there were other patients who felt they were affected by this treatment. They said they objected to all the extra medication given to this patient as it took needed supplies away from them. This was especially true in the case of the lubricant and they wanted their pills to go down just as easily. Unfortunately the end of this

story was lost in the pages of history. While it is known that the first patient was cured, even to this day it is not known whether the demands of the other patients were ever satisfied.

Now how does this story parallel the creation of the HSCRC, the Commission that is empowered to regulate the rates of hospi-The patient in the story goes through much the same process as did the representative of virtually all Maryland hospitals, the Maryland Hospital Association (MHA). The hospital's disease was high rates and financial troubles and in real life the cure came in 1971 with the passage of SB359, which added Sections 568H through 568X to Article 43 of the Annotated Code of Maryland. Our legislators in Annapolis are represented by the doctors in the story. The two doctors in charge of the case are in fact the two legislators who led the fight to have state regulation of the health care industry: Senator Rosalie S. Abrams and Senator Harry J. McGuirk. The role the dissatisfied patients played in the story in many respects resembles the role played by Blue Cross of Maryland as they are quite openly dissatisfied with many aspects of the law. Blue Cross, like the patients in the story, feels that some of the provisions in the legislation are concessions to the hospitals that at the same time take something from themselves.

This paper is in one sense a study of history, it has a story of its own to tell. But it is more than just history as it examines policy developments of many interest groups that helped to shape the final form of the cost review legislation under which the hospitals will soon operate. The format this study will use is chronological and will use the various legislative proposals

offered in Annapolis as its path through time. The point I hope to make though, is that it is not just the legislation and its success or failure which must be studied but also the reaction, opinions and concurrent inter-relationships of the interest groups that had the most at stake with the advent of rate review legislation. This paper will look not only at the aforementioned legislators, MHA and Blue Cross but it will look at reactions of the Maryland Comprehensive Health Planning Agency and the Mandel Administration.

So now the Commission's story begins, though it is much longer than the previous short parable, it nonetheless promises to be as entertaining and interesting.

The Formative Years, 1967-1969

The HSCRC can trace its earliest legislative history to a bill introduced in the House of Delegates by the then Delegate Rosalie Abrams in 1967. This bill, HB515 would have created a Council for Hospital Affairs, a board with very broad powers. Throughout her career in Annapolis the now Senator Abrams has been keenly interested in health affairs and is generally recognized by her colleagues as the legislator with the most knowledge in the area. Before entering the political arena, Abrams was a registered nurse and also has received a masters in the field of health study. She traces much of her interest in hospital costs to the Gruehn Commission, The State of Maryland Commission to Study Hospital Costs, chaired by Herman L. Gruehn in 1964. The commission's charge was "To examine all factors contributing to the rising cost of hospital services and to submit recommendations to change this trend without affecting the quality of care given in our hospitals." (p.i.) The commission, in its report to Governor J. Millard Tawes, listed eleven major areas for cost reduction, many of which appear three years later within the powers given to the Council created by HB515. In fact the proposed Section 568H of the bill is exactly the same as a section within the Gruehn Commission's Report entitled, Conclusions and Proposals. 568H outlines the powers of the Council for Hospital Affairs which include: ing the continuing task of achieving maximum economies in hospital operations by sponsoring investigative projects, assigning them to appropriate groups for execution and arranging for their financing

when necessary; bringing about better use of hospitals on the part of hospital staffs by encouraging a review of medical records of all discharged patients by utilization committees and by other means, studying and recommending what, if any, measures shall be taken to oversee hospital costs to the patient as well as to equalize the burden of hospital care given to those who cannot pay but do not qualify for aid under the state's program for the medically indigent." This section of the proposed bill addresses itself to some very nagging problems in the hospital industry that later become issues in future laws. "Overseeing of hospital costs" which more often is referred to as the problem of reasonableness of costs is the first, with the other being the bad debt issue, that is, who will pay the bills of patients who cannot or do not pay. Also under 568H the Council is given many powers in the realm of hospital planning. These powers include not only the review of plans for new hospitals and expansion of existing facilities but also developing plans to avoid duplication as well as "recommending and encouraging merger of hospitals or hospital services where feasible and in the overall community interest." The effects of this bill would have been far reaching, however, it was read for the first time upon introduction on February 21, 1967 and referred to the Committee on Ways and Means where it died without ever coming to a vote in the General Assembly.

Early in the 1968 session Delegate Abrams joined forces with Speaker of the House Marvin Mandel, Delegates Thomas Hunter Lowe and William M. Houck, in the introduction of a four bill package, HB273-276. HB273 was a successful bill that created the Maryland

Comprehensive Health Planning Agency (CHP), bringing the state in line with guidelines set up in the Federal Hill-Burton program. Its general function was to "set forth policies and procedures which are designed to provide for comprehensive State planning for health services." A major tool of the CHP was the certificate of conformance program that became law with the passage of HB274. This program, administered by CHP, provides that a license to open or continue a newly created hospital or related institution may not be issued unless the plans for the institution conforms to or is "not inconsistent with" the comprehensive health plan for that area. The other two bills in the package were designed to work together with HB273 so that a chain of command would have been established that would have overseen the entire health care system. Under HB275 the State Department of Health was given the responsibility for developing cost procedures and cost standards by which hospitals receiving funds from the State were to operate. Additionally, in a controversial portion of the bill, the Department was to have power to mandate services both to be added and to be taken away from facilities. Section 562A stipulates that there must be close coordination between the Department of Health and CHP as the plans of the Department are to be in accord with the comprehensive health plan developed by CHP.

A proposal for the operation of the Hospital Review Commission was the legislative intent of HB276. Its only power was to "determine the proper rates for payment for services at each hospital or related institution in this state which participates in Statefunded programs or which uses State funds." This bill was not

specific about how this was to be accomplished and further contained only a very general process for review of the Commission's decisions. It would not be unreasonable, however, to term this bill a very primitive forebearer of the HSCRC. This bill begins to set up a general outline according to which future bills were written. One of the reasons this bill did not get reported out of committee was that according to the Department of Health, Education and Welfare this bill did not conform to federal guidelines.

As quoted from an article in the Baltimore Sunpapers March 4, 1968, "A federal spokesman, 'insisted that a single agency had to be responsible for regulating Federally aided health ventures.'"

In addition to the above mentioned bills, the 1968 legislative session was a busy one when it came to action concerning hospital and health costs. While the Assembly was in session Governor Agnew's Special Ad Hoc Health Committee concerning Hospital Costs and Health Services Administration, the Nelson Committee, was at work on its report which was not released until June 12 of that year. Although Delegate Abrams was a member of this Committee, she introduced her legislation independently. While the Nelson Committee (chaired by Russell Nelson of Johns Hopkins Hospital) itself did not support the plan Abrams had introduced before the Legislature, it delayed recommending an alternate solution while the General Assembly was still in session. The Sunpapers of March 5 reports that the Committee wanted to get its own report together despite the fact it would not come out until 90 days after the legislature would adjourn. A major difference between the Committee's proposal and the proposal outlined in Delegate Abrams' bill

was that the latter provided that most of the commission members were to have no connection with the management or policy of any hospital, whereas the Nelson Committee's proposal suggests a commission heavily weighted in favor of those connected with hospitals or related institutions. In the previously mentioned article Delegate Abrams was critical of other members of the Nelson Committee, "Unfortunately most of the experts of the committee gained their knowledge by being trustees or administrators of hospital and are afraid of government regulation." Abrams in fact submitted a letter to Governor Agnew, dated March 19, which constituted a minority report in regard to the Committee's recommendations on cost control. The letter outlined twelve comments on the Committee's conclusions and recommendations.

Also during the 1968 session Senator Julian L. Lapides unsuccessfully submitted SB655, under the subtitle of "Hospital Costs Control" which actually would have done little to alleviate the problem in the State at that time. In Section 28E the Department of Health is authorized to do six things: The first three relate to standardization of reports regarding (1) the quality of treatment, (2) hospital costs and efficiency of operation, and (3) payments for the medically indigent. In a nebulous, unspecified manner the Department is also authorized to provide for: (4) the elimination of the incorporation of medical and nursing education and research costs in hospital costs, (5) the development of more efficient hospital management, and (6) for possible State subsidization of hospitals. Although there is an appeal mechanism set up there is no further elaboration on how these charges should

be carried out except for a stipulation that the Department should have access to all records. Although there is much room to criticize the details in Senator Lapides' bill these same criticisms can in no way be applied to the Senator's intentions behind introducing the bill. Lapides is very much oriented to the problems of his constituents and this bill was his way of attacking the spiraling medical costs he saw the public facing. In the following years the Senator demonstrated consistent support for bills that would have established state rate regulation of health care costs.

Delegate Abrams issued her answer to HEW objections in the 1969 session with the introduction of HB178 which would have established a Hospital Review Commission. Under Section 568-0, "Specific Grants of Duties and Powers," the Commission is given two basic powers: first a record keeping power, "To develop and from time to time revise systems of cost procedures which shall be required of hospitals and related non-profit institutions...." and second, the Commission, under subsections (2) and (3), was given the power of rate determination -- "to develop....programs,.... which may be established as cost standards," and "to determine those reasonable costs upon which rates for payment will be based of hospitals and non-profit related institutions who are to be reimbursed for services provided by them." Although the Commission is set up as an independent agency it is not made clear in the bill just how obligated the hospitals are to charge only those rates determined by the Commission. Under Section 568Q these determinations made on reasonable costs "shall be in accord with standards approved by the Secretary of the Department of HEW and included in the State

Plan." It therefore seems possible that the Department of Health, through CHP, as well as the Medicare administration, may have been able to bypass the rates determined by the Commission. During this session there are also two other bills that play a part, albeit minor, in the legislative history of the HSCRC. Companion bills, HB1351 and SB745 introduced by Delegate David J. Williams and Senator Edward T. Conroy, would have created the Health Facility Cost Review Commission. These bills are more specialized than those introduced by Delegate Abrams in that they are concerned about care given to state-aided patients. The Commission would be concerned only with those facilities participating in state funded programs and further it is charged with determining a reasonable cost to be paid to each facility so that state-aided patients may be "treated therein to the end that such patients may be assured a quality of care equal to that furnished other patients." Again, as was the history with most of the previous bills, these bills were read for the first time, and then referred to committee where they died.

In analyzing the bills that were introduced during these "formative years" there are two major explanations for their general failures. Firstly the hospitals at the time were absolutely against any form of regulation. The other reason, perhaps even more important, is that at the time Maryland was the first state to attempt this form of regulation. During this era the bills that were introduced were, in effect, experimental in nature, in a sense not unlike trial balloons. One Maryland Hospital Association official said to me, "The early bills were basically one-sided and

open-ended, with no protection to the hospital industry. It was poorly thought out and conceived legislation."

In essence I agree with this analysis. The bills had not yet reached the stage where they were sophisticated enough to have actually been effective. By the end of the 1969 session I feel the legislators had a better idea of the parameters of the problem they were trying to deal with. The intentions and the sentiments of the legislators remained the same in future years, unchanged from their desires in the formative years, but beginning in 1970 they were prepared to attack the problem of hospital rate regulation with realistic and workable legislation.

The Pivotal Year: 1970

Although 1970 was not unlike the immediately preceding years in that it was not marked with huge legislative gains, it nevertheless was the year in which many changes of strategies occurred. the legislative front the two major proponents of hospital rate regulation tried slightly different strategies which produced strong reactions from the health care industry. Senator Harry J. McGuirk introduced SB106 early in the session which would have created the Public Hospital Commission. This bill was patterned after existing public utility legislation and in effect would have made hospitals a public utility, subjecting them to the same regulation as the other public utilities like the power companies and the telephone company. The Public Hospital Commission created by this legislation would have been a very technical one, governed by forty-eight sections. of regulation. The actual powers given to the Commission were quite broad, to "supervise and regulate all hospitals subject to its jurisdiction, and shall enforce compliance by the hospitals with all the requirements of the law, ... " According to the provisions of this bill hospitals can collect only those rates specified in its schedule of rates (Section 11(a)(2)) and said schedule must be determined by the Commission, and can include a maximum or minimum rate (Section 20(a)); these rates were to be just and reasonable, meaning they would result in an income that would permit the hospital to operate on a solvent basis while rendering effective service without "exhorbitant or excessive" cost. Much of the bill is devoted to outlining the procedure to be used in changing the

rates, and since the Commission was created in the mold of the public utility regulations it is a formal and highly detailed procedure, thoroughly spelled out in the law. Essentially this bill has as its end hospital regulation, but its means are quite different than those outlined in previous bills. Most of the problems addressed to in the other bills, however, are also dealt with in SB106. Most importantly this would include provisions in Section 20 which in essence would have created a uniform accounting and reporting system.

Although the bill itself died in the Senate Committee on Economic Affairs it had strong implications for Maryland. Outwardly it seemed like many people did not take the proposal seriously. One source, observing the mood in Annapolis noted, "When McGuirk proposed his bill in 1970, everyone laughed at him." Senator McGuirk, however, was very serious about this idea. His concern was about the high costs of hospital care, "I wanted a consumer oriented spokesman," he recently related, "and this was one way to effect it." If some people in Annapolis were laughing at the bill, they didn't include the representatives of the hospitals. Richard J. (Dick) Davidson, the Executive Vice-President of MHA, says bluntly, "McGuirk frightened us to death." At the time the hospitals were against any form of regulation but they were especially hostile to the pure adaptation of the public utility model for hospital regulation. Donald C. McAneny, Assistant Director of MHA points out, "the language contained /in the bill is not appropriate for the regulation of hospitals. Our industry cannot be treated like a pure public utility in that we are a multi-institutional industry comprised of many hospitals throughout the State."

Shortly after the introduction of McGuirk's bill Delegate Abrams had nineteen of her colleagues join her in proposing HB400 which is a slightly reworked and more "sophisticated" version of HB178 of 1969. The changes in this bill are viewed as being quite important and although HB400 was unsuccessful it laid the groundwork for future, more successful legislation. This bill would have created the Hospital Review Commission, but there are two very important changes from the previous year. The first change, found in Section 568P, Specific Grants of Duties and Powers, gives the Commission power to "determine...rates to be charged by individual hospitals...for services to be provided by them." This clause clears up the confusion in the previous bill which had left the power of the Commission unsettled. The second major change is the inclusion of a section outlining the procedure for contesting the Commission's proposals for rates. This section makes the Commission a working, viable agency. The rest of the bill was carried over intact from the previous HB178, with the notable exception being a change in the composition of the Commission, with HB400 advocating fewer members.

Delegate Abrams met with her first degree of success later in 1970 when HB1092, under her sponsorship (and also with the sponsorship of the Speaker of the House), met with approval in the House of Delegates in a vote on March 18. However, its companion bill, SB547 died in the Senate Committee on Economic Affairs. In the upper house the bill was sponsored by Senators McGuirk and James A. Pine. HB1092 had as its main thrust rate regulation, but it differed from other legislation in that this responsibility was charged

to CHP. According to 562A(e) licenses issued by the State Department of Mental Health and Hygiene shall specify that the applicant hospital or related institution has been certified by CHP to be rendering effective services at reasonable charges to the public." To this end CHP is required to determine that each hospital or related institution is rendering these "effective services at reasonable charges" and in order to carry out this responsibility it has the power to examine all pertinent records of the institutions. Also contained within this bill was a provision that would have given the State power to mandate services at individual institutions. Although the effects of such a policy would be far-reaching, it inexplicably appears in some legislative proposals but is absent in others. In at least one source (Sunpapers May 11, 1970) it has been suggested SB549 died because of McGuirk's insistence that nursing homes be exempted from the bill's provisions. Senator McGuirk, admitting there is no great love between the Sunpapers and himself explains his actions, "At the time the State had a limit on payments for nursing homes but not for hospitals." He further suggests there would have been conflicts between this bill and the State's limit which would have resulted in deficits in the budget.

Although none of the above bills were able to gain approval in Annapolis they provided the impetus for two key policy changes that occurred after the 1970 Session was completed. At the urging of Senator McGuirk, SB547 and HB1092 were referred to the Legislative Council. Also during the summer and winter of 1970 there was a dramatic shift in the policies of the Maryland hospitals. First the actions and deliberations of the Legislative Council will be examined in detail.

The Legislative Council is a program that began in the Maryland General Assembly in 1955 so that proposals which were considered important could be studied closely between sessions of the Assembly. The Council of 1970 was divided into three major committees of ten members each, on which every member of the Assembly was given the opportunity to serve. A primary reason for the necessity of such a system lies in the briefness of the regular session in Annapolis which lasts for only 90 days. At the beginning of each session of the General Assembly, the Legislative Council submits for consideration the bills it worked on over the summer and fall. SB13 of 1971 was one of the fruits of the labor of the 1970 Legislative Council, however it became a dead-end in the lineage of the HSCRC. The Council actually had at least three options opened to it in its deliberations on state regulation of hospital rates. It could adopt one of the two routes opened in the previous session by using either the form of the public utility legislation as proposed by Senator McGuirk in SB106, or it also had the choice of making a recommendation along the lines of SB547 and HB1092, which did have more popularity throughout the state and the hospital industry. The third choice that the Legislative Council had was to make use of a private, non-profit organization, the Hospital Cost Analysis Service, Inc. (HCAS). This service was originally organized in 1960 to verify hospital costs. It later began a cost containment program (which is slated to end July 1, 1974) in which 39 of the 44 Maryland hospitals agreed to inspection. Under this program an investigation was made into any department of a hospital that reported operating expenses that were above the average reported

by similar departments in other hospitals of the same size. HCAS could make recommendations for cutting of expenses that could have been appealed to either Blue Cross, Social Security or the Department of Health and Mental Hygiene. The hospital could receive a reduction in reimbursements if the recommendation to save money were agreed with. At various times there were informal recommendations to make the HCAS the state agency to regulate the rates that hospitals could charge, but there was much criticism of this idea, especially from the hospitals. Donald McAneny seemed to sum up MHA's feelings the best, "HCAS was set up for auditing purposes, but not really officially as it had no role in evaluating the costs themselves. It only tested to see if the reimbursement formulae were being followed. It had no role as an official cost agency."

In the end the Legislative Council decided on none of these choices but rather a combination of the three, that in its attempt to be a compromise measure, satisfied virtually no one. The Economic Affairs Committee of the Legislative Council considered the legislative control of hospital rates in its sixth meeting on July 21. Minutes of this meeting, combined with an examination of the committee's records and a conversation with the legislative analyst for SB13, W. Porter Ellington, has convinced this author that the Legislative Council found itself trying to make a law in an area it was not familiar with and then found itself beseiged by the representatives of groups that had vital interests in the legislation it was preparing. SB13 (which was not reported out of the Senate Economic Affairs committee in 1971) was in a sense a potpourri of ideas that no group could support. The bill would have

created the Health Services Cost Agency whose jurisdiction was very weak. The only true power the agency had was outlined in Section 568Q where if a hospital's costs are determined by the agency to be unreasonable and are then not changed, the State "may withhold all or any part of payments or reimbursements for costs,..."

This means that the agency only has power in the area of state payments and the only action on costs would occur after the treatment had been rendered. Other responsibilities of the Agency were to prescribe uniform accounting procedures and to provide advice to hospitals on financial management. It was also given power to be a clearing house for information on hospitals. The main thrust of the bill, again, was the determination of reasonableness of the costs of services, a continuation of HCAS's work. Its true weakness was that the Agency could make only very limited recommendations, pertaining only to the State's payments.

As previously noted this bill was not supported by any of the major interest groups. MHA was not in favor of it. In a letter to the Legislative Council dated November 17, 1970 their position was stated:

Changing rates after appropriate proceedings and decisions is proper under public utility regulation; withholding of monies due the hospital under existing tariffs accompanied by possible besmirching of reputation, is not proper. This is not rate regulation, but rather regulation by guillotine.

The Mandel Administration was not supportive of the bill and neither was support coming from Rosalie Abrams, now a State Senator. Her feelings were that the bill did not go far enough in giving the Agency power. As quoted in the Sunpapers January 25, 1971,

she said the basis for her opposition was that the bill did not provide for pre-set rates for hospital costs, and that it allowed for State regulation, "only after the service had been provided."

She recommended that a gubernatorially appointed Commission develop a system for setting rates for medical treatment before the treatment is given.

By the time of Senator Abrams' previously quoted remarks, January 22, much had changed in Maryland, in fact, changes that had the major influence in providing enough support for a bill that would give the State power to regulate hospital rates. An outward sign had been in Governor Mandel's State of the State message in which he declared that a bill to regulate hospital rates would be "the cornerstone" of his consumer protection package. According to one of Mandel's top aides, Ronald L. Schreiber, Mandel had a personal interest in such legislation. "The Governor was very conscious of the situation regarding the inequities in the health care system," Schreiber noted, "and he felt it was time for legislation. I think that Senator McGuirk may have had some influence to get Mandel to back a bill at that time." But a major consideration was there was no bill to back. The Legislative Council was recognized as being unfeasible and there seemed to be no other bills forthcoming. However, on February 24, with the support of Mandel, Senators Abrams and McGuirk introduced SB359, the bill that was to eventually provide for state regulation of hospital rates. Interestingly, SB359 had been written by the hospitals themselves, in a complete about-face in their policy concerning rate regulation. Their changing of policy is a most important and extremely fascinating

part of history.

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This change in policy during this pivotal year of 1970 can in part be traced to the change in the organizational structure that occurred within the alliance of Maryland hospitals. The Maryland Hospital Council was created in 1955 but present MHA officials are not very positive that this group was truly representative of hospitals in the state. According to Dick Davidson the Maryland Blue Cross helped to form the Council and also helped to finance about 50% of its budget. This relationship changed drastically in 1970 when the hospitals reorganized themselves into the Maryland Hospital Association. Again in Davidson's words, "I feel that an arm's length relationship with Blue Cross is proper. When the old council went through the reorganization process to reorganize Blue Cross out, Blue Cross lobbied heavily to stay in--this was the first visible crack in our relationship."

A strong case can be made for this split becoming a major factor in the hospitals' change in carrying out the policy of regulation they finally adopted. Now when major decisions were made in the councils of the hospital association, Blue Cross was no longer a party to the decision making process. When this type of legislation was looked over within MHA, Blue Cross was not included, and this becomes a major factor as when the legislation was introduced, Blue Cross was its bitterest opponent.

The decision that the hospitals would now take a proactive role on the issue of state rate regulation went through a long decision making process within the MHA. First the hospitals felt that some kind of regulation was inevitable. In the words of James

J. Doyle, lobbyist for MHA in Annapolis, "The sentiment for passage was there \(\int \text{In Annapolis} \). I urged them \(\text{the MHA} \) to strike a compromise and get something agreeable to us or we would have something rammed down our throats anyway." This statement accurately reflects the feelings of those in the higher councils of the MHA. For instance, Davidson said that legislation could have been defeated temporarily but that its passage was only a matter of time. This view, however, is not shared by Fred M. Gloth, vice-president of Maryland Blue Cross, and who was also the lobbyist for Blue Cross at the time of the introduction of SB359. He feels that the hospitals' judgment at that time, "was in error" and that regulation wasn't imminent.

Once the decision was made to take an active role in the legislation a special committee on rate regulation was set up within MHA to examine alternative regulatory postures. According to Don McAneny the committee had four choices which were: 1) Do nothing and fight the bills coming through the Legislature; 2) Increase the authority of HCAS; 3) Set up a commission for disclosure only that would be modeled after the California commission; and 4) Set up a commission with a disclosure and rate-setting function. At the same time there was also an informal process developing wherein the leaders of MHA tried to get a feel of what its members wanted. In retrospect it seems evident these leaders had a good idea of what they wanted, but didn't know how it would be received by the members of the association. With the new structure of the MHA it was now the trustees of the hospitals and not the administrators that were in primary control of MHA's policy. This apparently made a

major difference in how the concept of rate regulation was now approached. With the new organization the people who were making the decisions were among the leading citizens in the community and undoubtedly these people were important factors in the acceptance of this idea. The leaders from among the trustees included people who had experience with regulation and they could help to lead the way. Included in this group was John W. T. Webb, a lawyer who represented the Delmarva Power Company and who was a trustee of Peninsula General Hospital and Herman L. Gruehn, the retired vice-president of the Baltimore Gas and Electric Company, who was president of the board of trustees of South Baltimore General Hospital. Also, according to Davidson, Eugene M. Feinblatt was counted on as the overseer of the philosophy, "Feinblatt, was the quiet leader." He is also a well-known Baltimore lawyer and a member of the Executive Committee of the Board of Directors of Sinai Hospital.

The decision by the special committee on rate regulation was that the retrospective cost reimbursement formula was no longer effective as it was arbitrary and had no cost efficiency incentives. The basic set of principles that were established by MHA at that time (according to McAneny) was that the present system was inadequate, especially for the public--with respect to accountability, understanding and that it had no built-in incentives for change. The MHA decided that what was needed was prospective ratesetting. There were a group of other factors that according to present MHA leaders helped to bring about the change. On one front the payments from Medicare and Medicaid weren't coming in on time and the hospitals in the inner city were having financial troubles.

There was also the fear of the possibility of fewer third party payors which would concentrate power into a small group and also the spectre of National Health Insurance that as described by McAneny, "would move power further away, and when there is a distance from the local communities the decisions tend to be more arbitrary."

The final proposal agreed upon within the policy making councils of the MHA was in fact the version of SB359 that went into the legislative hopper. The bill was conceived and written by the representatives of the hospitals.

When looked at from the perspective of the reorganization of the MHA that excluded Blue Cross, SB359 can be easily viewed as a power move on the part of the hospitals. There was no doubt that Blue Cross had an upper hand over hospitals by what Dick Davidson called, "regulation in its most primitive form. Hospitals...were a regulated industry. Third parties had been doing the regulating for years through rules and regulations, application of the reimbursement formulae, and through a general authority that permitted them to proclaim 'We will pay for what we will pay for.'" (Hospital Progress, September 1972)

The primary effect of this bill was to transfer the power to determine what the hospitals should be reimbursed for from the third parties to the new state agency, the Health Services Cost Review Commission. The problems that the bill had in getting approval from the legislature was for the most part due to the opposition it received from Blue Cross. The views of Eugene Feinblatt help to capsulize why SB359 was resisted by Blue Cross. On one hand, he says, the organization of Blue Cross was resisting changes in the institutions that had remained constant for many years. Secondly, he explained, "as a basic part of public utility legislation there is non-discriminatory treatment, however, Blue Cross didn't want to lose its favored status and be forced to pay bad debts." With this overview, from the hospital perspective, it is also important to examine the other side of the coin, the perspective of Blue Cross. In any of his comments concerning the MHA and

SB359, Fred Gloth (of Blue Cross) is quick to point out his opposition to the bill and the basic theories hospitals utilized in its preparation. "At the onset he is vehemently opposed to the new organization of the MHA and the "arms length" situation Blue Cross now finds itself in when looking at the hospitals. He regrets that Blue Cross has never had any representation on the board of the MHA while, on the other hand, one-third of the board of Blue Cross is made up of providers. "Instead of an adversary role the community would be better off if there was cooperation," he comments.

Generally, however, the view of the two organizations squaring off nose to nose is the basis for Blue Cross' objections to this form of rate review legislation. In the past Gloth said that his organization had no concern about previous legislation dealing with rate review by the state, noting confidently, "We didn't think that any of the other bills would pass." This author suggests that one reason for their lack of concern was due to the influence Blue Cross had in Annapolis. It seems safe to theorize that the fact that none of the bills passed was not coincidental with the fact that there was some influence exerted.

In Blue Cross' mind the situation changed when the hospitals decided they were to be regulated. It was the Blue Cross position that if the hospitals decided they were to be regulated it would be hard to keep this regulation from occurring. It was important, though that Blue Cross make suggestions in the form of amendments so that their interests, too, were represented in the legislation. This is the analogy of the patient taking the pill: Blue Cross couldn't tell the patient not to take the pill, however, when it

was realized what was involved in the action of taking the pill,
Blue Cross was not about to be put at any disadvantage and felt it
imperative that its own interests were represented.

The opinion of Dick Davidson is that Blue Cross, "viciously lobbied against the bill and used dirty politics," but when brought into perspective Blue Cross felt very threatened by some of the concepts embodied in SB359. In Gloth's view, "The hospitals got together and wrote up the best legislation they could perceive-it guaranteed profit and success." Blue Cross makes it clear that the HSCRC should be concerned about the efficiency of hospitals and not guarantee their "unconditional perpetuity." Another very basic point of opposition is the inclusion of bad debts into the costs of all patients. Bad debts are those monies that the hospital is not able to collect from patients who pay their own bills. About 80% of the patients are covered by third party payors and from this group there is very little bad debt generated. However, about 25% of the other patients are not able to pay for their own bills. Historically Blue Cross has not recognized this bad debt the hospital is saddled with as part of the rates it should pay. it pays for its own patients and therefore shouldn't have to pay for the bad debts of others. This system causes some huge inequities in the payment for health services and greatly inflates rates for patients who pay their own bills.

Consider the following example from Issues in State Rate
Regulation by Harold A. Cohen, Executive Director of the HSCRC:

Cost per day as defined by Blue Cross, Etc.-\$80.00
Assume these are actually correct costs and 80% of
the patients bills are settled on this basis. Then, since

only three quarters of the other 20% of patients pay their bills, the required average charge is \$106.70. That is .80 (\$80) + .15 (106.70) = \$80 average received payment per day.

If bad debts were evenly distributed, then the required charge would be \$84.21. That is

.95 (\$84.21) = \$80 average received. Thus if bad debts were spread evenly over all patients, as it is in most retail operations, hospital rates (charges) could be reduced, in this representative example, by 21% from 106.70 to \$84.21.

Blue Cross predicts that they will be the only third party that will have to pay a portion of the bad debts. Gloth paints a scenario of what would happen: "With Blue Cross paying a share of the bad debts it won't be merely a redistribution of expenses. Will the State pay more? Will the Federal government pay more? Will private insurers, having fixed dollar amounts pay more? Who will pay more? Though there are only a few cash paying patients it is they who cause the bad debts. We don't want to be concerned with the bad debts of others; this would mean the subsidization of Federal programs and of private insurance companies by Blue Cross."

The hostility with which the HSCRC is now viewed by Blue Cross was especially evidenced three years ago, during the time period the sponsors of SB359 were trying to gain the passage of their bill. To complete the history of the HSCRC this era will be examined in more detail.

One of the decisions that needed to be made in the drafting of SB359 was where the Commission was to function within the network of the state bureaucratic organization. At first there seemed to be only two choices, that the Commission could be an independent agency or it could operate under the jurisdiction of the State

Department of Health and Mental Hygiene. In most of the earlier

bills the state agencies that would have been established would have been independent and reporting to the Governor. This trend changed with the bills in 1970 that would have created the agency as part of CHP and also in the proposal that came out of the Legislative Council that would have placed the agency within the Department of Health and Mental Hygiene. The solution that was finally reached was incorporated into Section 568I of SB359 and stipulates that the Commission should be, "an independent commission functioning within the Department of Health and Mental Hygiene." There were several factors that made this type of compromise necessary. One must remember that as Governor Mandel took office he inherited a state system in which hundreds of agencies reported directly to his office. According to Secretary of Personnel, Henry G. Bosz, the reorganization of the state government was Mandel's first priority upon entering office. When this was accomplished Mandel had a version of the cabinet system set up to streamline the chain of command through the state's agencies and it was during this time that the State Department of Health and Mental Hygiene took form as it presently operates.

It was felt by many people in the state that the creation of the cost review agency should not go against the general thrust of the reorganization that had so recently been completed. At the same time, however, there was also the sentiment that the Agency should not be under the influence of the Department of Health and Mental Hygiene as this was the agency in charge of the state's medicaid system and therefore was not only the largest provider of health care through the state hospitals, but was also one of the

largest health payors in the state. Under this final compromise, explained Fredrick Nevins, Associate Executive Director of CHP (who was involved with the negotiations that led to the solution), the agency would be "independent in its daily operations and in its own policy decisions, but would be under the Department for administrative purposes."

There are also some other technicalities in the bill that bear note because of the influence they have on the deliberations of the HSCRC. The most advantageous way to look at these is within the framework of the chronology of the bill, from its introduction and first reading on February 24, until its passage by the House of Delegates April 5. In the days immediately after the introduction of SB359 the senate acted quickly to expedite the consideration of the bill. On March 16 it received a favorable report from the Committee on Economic Affairs with sixteen amendments adopted. the whole the amendments were of a technical nature, merely the insertion or deletion of words or phrases for grammar and clarity. There are three exceptions that should be dealt with separately. Amendment 8 inserts the underlined words into the following portion of Section 568U: "and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination or preference." These additions seem to leave little doubt that the third party payors, including Blue Cross, are to share equally in the payment of rates, that in an earlier portion of 568U are stipulated to be reasonably related to aggregate costs.

Amendment 10 which was eventually defeated changes a segment of 568V that would have helped the third parties to escape from

paying a portion of the bad debts. According to the original bill within Section 568V the following appeared: "In determining the reasonableness of rates, the rates should be sufficient to provide for all reasonable and necessary operating expenses, including appropriate expenses incurred for rendering services to patients who cannot or do not pay,... "the section continues with other expenses includable in rates). The amendment would have moved this section to after the other expenses includable in rates and would have started a new sentence with, "'Reasonable and necessary operating expenses' shall also include the expense incurred for rendering services to patients who cannot or do not pay; but no more than a proportional share of such unpaid amounts shall be included in the total rates payable by any one major class or purchasers, insurers, or other third party payors." The additional material after the semicolon would seem to place a limit on the amount of bad debt that any third party would have to pay. In the final version of this section, however, there was a major alteration that has become a center of controversy between the HSCRC and Blue Cross. 568V in the final form provides that the Commission shall, "compile all relevant financial and accounting data in order to have available the statistical information necessary to properly conduct rate review approval. Such data shall include...appropriate expenses incurred for rendering services to patients who cannot or do not pay...(other categories of expenses are then listed). The Commission shall define and prescribe by rule the types and classes of charges which cannot be changed except as provided by the following procedure..." The HSCRC has interpreted this section to include

these expense categories as properly includable in rates, including those rates that would be charged to Blue Cross subscribers. Blue Cross, on the other hand, in a legal memorandum presented to the Commission on May 29, 1974, takes the position that in this section the Commission is given the power to only collect this data. The memorandum, prepared by Fred Gloth and the firms of Niles, Barton & Wilner of Baltimore and Breed, Abbott & Morgan of Washington,

D. C., attorneys for Blue Cross, further states that because of its interpretation of this section, "the Commission thus threatens not only to rewrite the statute but to undo the very thing the General Assembly did in its consideration of the bill." (p. 54) The final amendment to be noted is number 14, which would have moved up the Commission's rate setting function to July 1973 in lieu of the original date, July 1974. This amendment was later defeated.

The next day Senator James J. Bishop, a board member of Blue Cross offered five amendments to the amendments. On the following day, March 18, Senator Pine gave a favorable report to these amendments but Bishop withdrew his previous amendments and offered five more instead of the others. The changes, however, between the sets of amendments are only technical. Friday March 19 brought another favorable report from the Economic Affairs Committee and for the fourth consecutive day the bill was made a special order for the next day the Assembly was in session. It was on this day, March 22 that important events take place that enabled the eventual passage of SB359 to occur, but first the five amendments offered by Senator Bishop must be examined so that their potential impact can be understood.

The amendments offered by Bishop would have effectively gutted the bill. Their intent was to make the wording of the bill more palatable to Blue Cross and therefore would have destroyed what is viewed as a basic aim of the bill: to evenly spread out the cost of bad debts. In amendment 17 offered by Bishop the effects of the aforetomentioned amendment 8 would have been negated. Aside from the purely technical changes it would have produced, this amendment would have also deleted the phrase that rates are to be set: without undue discrimination or preference. As the grammar in the previous sentence indicates, this amendment was not part of the final version of SB359. Amendment 18, which was also unsuccessful, would have substituted the word "higher" for "other" in the following passage in 568U: "No institution shall charge for services at a rate ether higher than those established in accordance with the procedures established hereunder." This phrasing could leave room for the possibility for Blue Cross to go through the Commissioner of Insurance's office in order to have a rate approved for them that could be lower than what the HSCRC had previously determined to be the proper rate, adjusted for the costs of the institution in providing that service. Amendment 19 was technical in nature and did appear in the approved version of the bill.

Another striking example of where an attempt was made to circumvent the legislative intent of SB359 can be found in Bishop's proposed amendment 20. This amendment would have been applied to the same portion of Section 568V as did the previously discussed amendment 10. This amendment rewrites a major portion of 568V, generally making no significant changes. However, within the lines

of the amendment that address themselves as to what should be included in establishing reasonable rates, all mention to the inclusion of bad debts is deleted. Leaving out this section produced a major change in the content of the bill, not at all consistent with the original intent of its initial drafters. The final amendment offered by Bishop provided for additional, basically technical changes that were not accepted in the form in which they were introduced; however, later, some of these changes were incorporated into the bill.

With these amendments looming in the future it appeared that there might have been a major battle on the floor of the Senate on Monday, March 22. During the prior week, Davidson noted that any time anyone on the floor would rise to speak on the bill, they would first look into the gallery to see if Fred Gloth of Blue Cross was there. It was at this point, however, that Governor Mandel intervened to try to bring the disagreeing sides together. Davidson again points out that, "this had become his bill in that he had accepted our bill. He had something at stake personally." And indeed, there can be no dispute to Davidson's remarks. had described this bill as the cornerstone of his consumer protection package and had promised in his State of the State message that the bill will "effectively control rising hospital costs." There are many accounts of the meeting that Mandel arranged between his Lieutenant Governor, Blair Lee, III, and representatives of the various interest groups which had interests at stake in the bill. Lee himself remembers little about the meeting. He says that he sees his role as the one who "sorts out conflicts between groups,"

and that the events surrounding SB359 had happened very long ago and that much had taken place in the meanwhile. Eugene H. Guthrie, who only recently resigned as Executive Director of CHP, remembers the meeting as a "wrap-up session to make sure we all knew what was happening. There was a great desire that the interests could be reconciled; it was the specifics and not the concepts that were causing trouble." Finally Ron Schreiber recalls, two meetings, "one was out in the bill signing room, but there were too many people there. A smaller group of representatives was brought into the office of Blair Lee--he was the peacemaker. As a result of this meeting the amendments were hammered out." Newspaper accounts of the meeting also vary. What is certain is those in attendance, besides Lee, Senators McGuirk, Abrams and Bishop were there as were representatives of MHA in the persons of Davidson and Feinblatt. Fred Gloth was in attendance representing Blue Cross, Charles A. Della was there as the representative of the AFL-CIO, and there was also a representative of the Hospital Cost Analysis Service at the meeting.

What did the press see as occurring at the meeting? It was held "to draft amendments to make the bill more palatable to its critics, principally John Bishop. Under the amendments workout the Commission would have greater flexibility in determining 'reasonable' rates." (March 23, Evening Sun) As a result of the meeting, the Morning Sun of March 23 stated, "Blue Cross thinks it may have escaped the bad debt problem." Another account of the meeting said that it cleared away most of the objections to the bill, "The compromise apparently relieved Blue Cross of the obligation of assuming

some or all of the bad debts." (April 6, 1971, Morning Sun) The problem, then is one of sorting through all these versions of the meeting and to determine just what did happen in Blair Lee's office at this very crucial juncture of time. Viewing the situation with some hindsight it does seem certain that Blue Cross came out of Lee's office in the posture of not being in favor of the bill but, on the other hand, it was no longer going to lobby actively against it. The amendments that Bishop offered were withdrawn, thus avoiding possible open battles on the floor of the Senate. In the final analysis the hospital's views prevailed. In the words of Dick Davidson, "There were some language changes (soft language was negotiated), but we all knew the intent."

Although the meeting enabled the senators to avoid some disagreements on the floor of the Senate later, during the evening of March 22, in a night session, there emerged some disagreements over an amendment offered by Senator McGuirk (one of the bill's sponsors). First he moved to reconsider the vote by which amendments 10, 11 and 14 were adopted. This motion prevailed by yeas and nays. He then introduced amendment 17, in which the following deletions would have been made within 568J which sets forth the composition of the Commission: "The Commission shall consist of seven (7) members, who shall be appointed by the Governor. The appointees shall be persons who are interested in the problems of health care, of which four (4) shall be persons who have no connection with any

hospital or related institution. It was attacked by Senator John C. Coolahan in the March 23 Evening Sun as "it would have permitted hospitals to control the commission." Originally this amendment was approved, as were four other amendments offered by McGuirk.

Amendment 17, however, barely passed by a margin of only one vote, 20-19. Senator Abrams, the other sponsor of the bill, moved to reconsider the vote by which amendment 17 was adopted, although she had previously voted for it. Her motion prevailed and in a second vote the amendment was rejected by yeas and nays; therefore this portion of the bill remained unchanged. It seems interesting that the two co-sponsors of the bill should disagree at such a late stage in the bill's consideration. McGuirk clarified his position when he stated that he felt the work of the Commission would be expedited if there were "experts involved at the beginning."

The bill was now in its final form. It was read for the second time and ordered printed for its third reading. SB359 received its third reading on March 24 and was passed by a vote of 31-8. Senator Bishop was among those casting dissenting votes. Interestingly enough, however, the Sunpapers only the day before had noted that the supporters would still not immediately claim victory, because of the possibility of unforeseen impediments. History shows that despite these worries the bill was passed in the House of Delegates on April 5.

The bill's effect on the legal code in Maryland was to add Sections 568H through 568X to Article 43 of the Annotated Code of Maryland. The Health Services Cost Review Commission created by the bill has strong control over the health care industry, the

second largest industry in Maryland and, in effect, makes all institutions public utilities. The Commission has two major areas of responsibility. The first was to cause the public disclosure of the financial positions of the hospitals and related institutions. This power is outlined by law in Section 568P. The Commission was also given the power to establish a "uniform system of accounting and financial reporting, including cost allocations as it may prescribe", in Section 568-0. This uniform accounting and reporting system was needed to assist the Commission to approve rates, which was its second major responsibility. The Commission is directed in Section 568H (Legislative intent) to "assure all purchasers of health care hospital services that the total costs are reasonably related to the total services... that the aggregate rates are set in reasonable relationship to the hospital aggregate costs...and that rates are set equitably among all purchasers or classes of purchasers of services without undue discrimination." It is further specified in Section 568U that, "No hospital shall charge for services at a rate other than those established in accordance with the procedures established hereunder," and also that, "the Commission may promote and approve alternate methods of rate determination of an experimental nature that may be in the public interest and consistent with the purposes of the subtitle." These same two excerpts led the Executive Director of the HSCRC, Harold A. Cohen to note in a recent paper that, "The rates the Commission sets are thus both maxima and minima." (Issues in State Regulation, p. 4)*

^{*}Please consult Appendix I, for important additional information.

Other sections of the bill seem to provide the Commission with a strong base from which it can operate. As previously noted the majority of the Commission is consumer based, with four of the seven commissioners barred from having any connection with the management or policy of any hospital or related institution (Section 568J). As a further safeguard, in the absence of some of the consumer members, the three industry representatives must still have at least some consumer support as Section 568J stipulates that "no action of the Commission shall be effective unless at least four of its members concur therein." Along with various other administrative powers given to the Commission, the enabling act also outlines the procedure which institutions must follow if they wish to charge rates other than those approved by the Commission. As outlined in Section 568X these procedures provide the institutions a reasonable opportunity to present any protests in an orderly fashion. This procedure was not as clearly outlined in many of the preceding attempts to establish state rate regulation in the health care industry. It is important to emphasize that this specified procedure, in conjunction with the rate approval powers of the Commission, will in the future, once the initial rate approval round is completed, make the HSCRC a quasi-judicial agency.

Before signing the bill the Governor was in receipt of two separate documents from the State's Attorney General's Office attesting to the constitutionality of SB359. The first, dated March 10, 1971 and signed by the Assistant Attorney General Richard G. McCauley, approved the bill as it was introduced. The second

letter, sent directly to the Governor by Attorney General Francis B. Burch after the passage of the bill, states: "While the title does not explicitly state that the Commission has the power to review and approve the reasonableness of the rates of hospitals and other health care institutions, we believe that it meets the constitutional test for titling,.... We are of the opinion that the above-captioned bill is constitutional and may be signed by you."

Note that in this last excerpt it is not a question of the bill's contents, but rather its structure that was clarified. The way was paved for the signature of Governor Mandel and the bill became law July 1, 1971.

The legislative history of the Commission as limited in this study ends at this point. Beginning on July 1, 1974 the hospitals will not be able to charge rates unless they are approved by the Commission. It is still not known how outside parties will react to the Commission's use of its authority. To be truly effective the new rate schedules must be adhered to by all purchasers or classes of purchasers. These categories would necessarily include Blue Cross, Medicare and Medicaid. It is also uncertain how the hospitals will react to the rates the Commission has approval over. It is probable that the true power and authority of the HSCRC will not be determined until the outcome of the court cases, that will surely ensue, are decided. There are many views on whether the Commission will be successful in controlling health care costs. Richard Davidson of the MHA takes the position that, "if it /the HSCRC doesn't work we'll try something else." Fred Gloth of Blue

Cross is quite pessimistic about the ability of the Commission to control rates. He feels quite certain that hospital rates will go up as will the rates that Blue Cross will charge its subscribers.

But, whatever the outcome, Maryland is taking a positive first step in combating the rising costs of health care. The National Observer of May 18, 1974, found that in 10 randomly selected states, Maryland was one of only two states actively working for a solution in this area. It remains to be seen if the HSCRC approach will work to curb costs in the hospital industry, much of the battle yet to come may ultimately be fought in the courtroom. If this is in fact the outcome, the legislative history will be most important in determining the intent of SB-359 and if the actions of the HSCRC have been within the parameters of the enabling act.

APFENDIX I

APPENDIX I

On June 4, 1974 the HSCRC made a decision to completely change their methodology in that the Commission would not set rates, but rather, would review and approve rates submitted by the individual institutions. The major impetus for this decision were the statements made by James J. Doyle, a lawyer for the MHA, at the Commission's public hearing May 29. At the hearing the HSCRC was reminded by Doyle that its legislative charge nowhere gives the power HSCRC to actually set rates—only to approve them.

In the long run the distinction may only be a legal technicality. It appears as if the hospitals will work in close cooperation with the Commission in setting rates. At worst it could be an extended period of time until the first round of rates are agreed upon by both the hospitals and the Commission.

This change in the methodology came one day after the final draft of this paper was completed. The change did necessitate some minor revisions in this paper and upon further proofing it appears as if all necessary corrections were made.

APPENDIX II

Appendix II

- 1. Minutes of the Legislative Council Economic Affairs Committee
- 2. Previous Legislation

1967 HB515

1968 HB273 '

HB274

HB275

HB276

SB655

1969 HB178

HB1351

SB745

1970 HB400

HB1092

SB106

SB547

1971 SB13

SB359 (in final form)